

CALIFORNIA FUNCTIONAL CAPACITY PROTOCOL
Health Questionnaire

Evaluee: _____ Date: _____

Directions: If you can answer **YES** to the question asked, put a circle around the **YES**.
If you have to answer **NO** to the question asked, put a circle around the **NO**.
Answer all questions. If you are not sure, guess.

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|-----|---|-----|----|
| 1. | Do you need glasses to read? | YES | NO |
| 2. | Do you need glasses to see things at a distance? | YES | NO |
| 3. | Do you wear contact lenses? | YES | NO |
| 4. | Are you hard of hearing? | YES | NO |
| 5. | Do you wear a hearing aid? | YES | NO |
| 6. | Do you suffer from asthma? | YES | NO |
| 7. | Are you troubled by constant coughing? | YES | NO |
| 8. | Have you ever coughed up any blood? | YES | NO |
| 9. | Do you sometimes have severe soaking sweats at night? | YES | NO |
| 10. | Do you suffer from angina (heart pain in the chest or arm)? | YES | NO |
| 11. | Have you ever had a heart attack? | YES | NO |
| 12. | Does heart trouble run in your family? | YES | NO |
| 13. | Have you ever had an electrocardiogram? | YES | NO |
| 14. | Have you ever had a stress (exercise tolerance) test? | YES | NO |
| 15. | Do you wake up at night short of breath? | YES | NO |
| 16. | Has a doctor ever said your blood pressure was too high or low? | YES | NO |
| 17. | Have you ever been told of high blood cholesterol? | YES | NO |
| 18. | Do you have pains in the heart or chest? | YES | NO |
| 19. | Does your heart often race like mad? | YES | NO |
| 20. | Do you find it hard to breathe? | YES | NO |
| 21. | Do you get out of breath long before anyone else? | YES | NO |
| 22. | Do you suffer from swollen ankles? | YES | NO |
| 23. | Have you ever taken water pills? | YES | NO |
| 24. | Have you ever been told of a heart murmur? | YES | NO |
| 25. | Have you ever been told of a problem with your heart valves? | YES | NO |
| 26. | Have you recently gained weight? | YES | NO |
| 27. | Have you recently lost weight? | YES | NO |
| 28. | Have you ever had any surgery? | YES | NO |
| 29. | Have you ever had any broken bones? | YES | NO |
| 30. | Do you suffer from weak or brittle bones? | YES | NO |
| 31. | Do you use aspirin, Tylenol® or ibuprofen regularly? | YES | NO |
| 32. | Do your muscles or joints often feel stiff? | YES | NO |
| 33. | Do you often have severe pains in the arms or legs? | YES | NO |
| 34. | Do you have weak or painful feet? | YES | NO |
| 35. | Do pains in the back make it hard for you to keep up your work? | YES | NO |
| 36. | Are you troubled with a serious bodily disability or deformity? | YES | NO |
| 37. | Do you have any chronic skin conditions? | YES | NO |
| 38. | Do you suffer from frequent headaches? | YES | NO |
| 39. | Do you often have pressure or pain in the head? | YES | NO |
| 40. | Do you often have spells of dizziness? | YES | NO |

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| 41. | Do you often feel faint? | YES | NO |
| 42. | Have you fainted more than twice in your life? | YES | NO |
| 43. | Do you have often have numbness or tingling in any part of your body? | YES | NO |
| 44. | Was any part of your body ever paralyzed? | YES | NO |
| 45. | Were you ever knocked unconscious? | YES | NO |
| 46. | Did you ever have a fit or convulsion (epilepsy)? | YES | NO |
| 47. | Has a doctor ever said you had a hernia (rupture)? | YES | NO |
| 48. | Do you often get spells of complete exhaustion or fatigue? | YES | NO |
| 49. | Does working tire you out completely? | YES | NO |
| 50. | Does every little effort wear you out? | YES | NO |
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| 51. | Are you constantly too tired and exhausted even to eat? | YES | NO |
| 52. | Are you frequently confined to bed by illness? | YES | NO |
| 53. | Are you always in poor health? | YES | NO |
| 54. | Do severe pains and aches make it impossible for you to do your work? | YES | NO |
| 55. | Do you suffer from any chronic disease? | YES | NO |
| 56. | Are you definitely <i>under</i> weight? | YES | NO |
| 57. | Are you definitely <i>over</i> weight? | YES | NO |
| 58. | Have you ever had a serious injury? | YES | NO |
| 59. | Do you suffer from diabetes? | YES | NO |
| 60. | Do you usually have great difficulty in falling asleep or staying asleep? | YES | NO |
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| 61. | Do you smoke more than 20 cigarettes a day? | YES | NO |
| 62. | Do you drink more than six cups of coffee or tea a day? | YES | NO |
| 63. | Do you usually take two or more alcoholic drinks a day? | YES | NO |
| 64. | Have you ever taken non-prescription drugs? | YES | NO |
| 65. | Do you frequently use over-the-counter medicines? | YES | NO |
| 66. | Do you use sleeping pills? | YES | NO |
| 67. | Do you use vitamins regularly? | YES | NO |
| 68. | Do you take iron pills regularly? | YES | NO |
| 69. | Have you ever needed the services of a chiropractor? | YES | NO |
| 70. | Do you regularly take tranquilizers or sedatives? | YES | NO |
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| 71. | Do you usually feel unhappy and depressed? | YES | NO |
| 72. | Do you often cry? | YES | NO |
| 73. | Are you always miserable and blue? | YES | NO |
| 74. | Does life look entirely hopeless? | YES | NO |
| 75. | Do you often wish you were dead and away from it all? | YES | NO |
| 76. | Does worrying continually get you down? | YES | NO |
| 77. | Does every little thing get on your nerves and wear you out? | YES | NO |
| 78. | Are you easily upset or irritated? | YES | NO |
| 79. | Are there any medications you are supposed to take that you are not taking? | YES | NO |

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Reviewed by: _____ Date: _____